DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445174	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKHAVEN MANOR	2035 STONEBROOK PLACE KINGSPORT, TN 37660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.70(a) K3 BUILDING: 1-story, Type V(111), unprotected, combustible construction with a complete automatic dry sprinkler system that covers 47,000 SQFT separated by two 4-hour firewalls resulting into into three (3) separate " buildings ". K6 PLAN APPROVAL: 1984 K7 SURVEY UNDER: 2000 EXISTING K8 SNF Licensed for 180 beds with a census of 161 on the day of the survey. The annual Recertification Life Safety Code survey was completed on November 7-8, 2011 with an Extended survey completed on November 8, 2011. The facility was cited with an Immediate Jeopardy. The Administrator was notified of the Immediate Jeopardy on November 7, 2011 at 4:00 p.m. in the Administrator's office. The Immediate Jeopardy for tags K-62 and K-154, at scope and severity levels of an "L", was effective from October 10, 2011 through November 8, 2011. On November 8, 2011 the facility provided an acceptable allegation of compliance lowering the Immediate Jeopardy. The scope and severity for K-62 and K-154 was lowered to an "F" level.	K 000	K 021 The Maintenance Director on November 18, 2011 did an audit of all fire doors in the building to check for positive latch. A new set of fire doors were ordered on November 18, 2011 for 100 Hall and will be placed when received. Completion Date: November 30, 2011 The Maintenance Director or Maintenance Assistant will conduct checks of fire doors to ensure positive latch during the monthly preventive maintenance rounds. The checks will be submitted monthly for six months to the Quality Assurance Committee, who will determine the need for future focus. The Director of Maintenance or the Maintenance Assistant will report the findings to the Quality Assurance Committee (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.).	11/30/2011
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon	K 021		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christopher A. Gaddy — TITLE: Administrator — (X6) DATE: 11/21/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 021	Continued From page 1 activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure corridor fire doors would close to a positive latch. The findings include: Observation and interview with the Maintenance Director, on November 7, 2011 at 1:00 p.m. confirmed the corridor fire door by room 107 failed to close to a positive latch.	K 021	K 050 The Director of Maintenance conducted a 100% audit on November 18, 2011 of 2011 fire drill to ensure all drills had been completed per regulation. Beginning on November 21, 2011 once a fire drill has been conducted it will be given to the Administrator for signature and fire drills will be submitted to the Quality Assurance Committee on a quarterly basis. The Maintenance Director or the Maintenance Assistant will report overall findings to the Quality Assurance Committee (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.)	11/21/2011
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050		

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K 050	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure fire drills were conducted quarterly on each shift. The findings include: Record review on November 7, 2011 at 9:00 a.m. confirmed a 2nd shift fire drill for the 4th quarter of 2010 had not been conducted.	K 050	K 052 On November 15, 2011 the sensitivity test was completed on smoke detectors in the building. On November 18, 2011 an audit tool was created to track the due date of the smoke detector sensitivity test. The Director of Maintenance or the Maintenance Assistant will report the findings of the audit tool to the Quality Assurance Committee (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.) on a yearly basis.	11/21/2011
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: NFPA 72, 7-3.2.1 Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of	K 052		

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K 052	Continued From page 3 detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. Based on record review, the facility failed to assure smoke detectors were tested for sensitivity every two (2) years. The findings include: Record review on November 7, 2011 at 10:30 a.m confirmed the last smoke detector sensitivity test was completed on 9-28-2009.	K 052	K 062 **Corrective action(s) accomplished for those residents found to have been affected:** All residents had the potential to be affected. On November 7, 2011 the fire watch policy was implemented immediately by the Director of Maintenance.	11/21/2011
K 062 SS=L	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the sprinkler system was maintained and operable. The facility's failure placed all 161 residents in the facility in Immediate Jeopardy (a situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious harm, injury, impairment or death. The Administrator was notified of the Immediate Jeopardy on 11/7/2011 at 4:00 p.m. in the Administrator's office. The findings include:	K 062	**How other residents having the potential to be affected were identified and corrective action(s) accomplished:** Beginning on November 7, 2011 the fire watch policy will stay in effect until the new sprinkler system is inspected and the Department allows us to lift the watch. On November 18, 2011 the Assistant City of Kingsport Fire Marshall inspected the new system. Also training was done with the Kingsport Fire Department on the new system. On November 18, 2011 at approximately 1:15 pm per a phone conversation with State Fire Inspector fire watch was lifted for the building. **Measures or systematic changes put into place to ensure the deficient practice does not recur:** The old sprinkler system has being replaced with a new system. As of November 17, 2011 the new system is fully functional and being monitored. As of November 18, 2011 any reports on the sprinkler system will be given to the Administrator for signature.	

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K 062	Continued From page 4 Record review and interview with the Maintenance Director, on November 7, 2011 at 3:45 p.m. revealed the sprinkler system, consisting of a single dry sprinkler riser supplied the entire 47,000 sqft building. This has the potential to affect all 161 residents, staff, and visitors in the facility. Record review and interview with the Maintenance Director, also revealed the facility failed to have a dry system trip test annually. Sprinkler records were reviewed beginning with July 9, 2007. There was one dry system trip test record dated October 10, 2011. Review of the trip test report from October 10, 2011 resulted in a time of 8 min 30 seconds for the dry valve to trip open. This failed to meet the 60-second limit for water to flow from the inspectors test valve connection and indicated the sprinkler system failed to function as designed and was inoperable on from October 10, 2011. Interview with the Sprinkler company service technician over the telephone, on November 7, 2011 at 3:30 p.m. confirmed the dry system trip test was unacceptable and this was discussed this with the Maintenance Director and Administrator. The facility failed to perform any corrective actions as a result of the unsatisfactory test. The Immediate Jeopardy was removed on November 8, 2011 at 2:40 pm when the facility provided an acceptable Allegation of Compliance and had properly initiated a firewatch for an inoperable sprinkler system. The scope and severity for K-62 was lowered from an "L" level to a "F" level. Interviews and observations on November 8, 2011 beginning at 9:10 a.m. with Certified	K 062	K 062 cont. **Quality Assurance program put into place to monitor corrective actions and ensure the deficient practice will not recur:** As of November 17, 2011 the new system will be put on a regular maintenance program to keep it in operation with current regulations. The Maintenance Director or the Maintenance Assistant will report any issues to the Quality Assurance Committee (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.) on a ongoing basis.	

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K 062	Continued From page 5 Nursing Assistants, Licensed Practical Nurses, Registered Nurses, Physicial Therapy Aides, Technicians, and the Director of Nursing revealed staff had been in-serviced related to the need for the fire watch and facility staff were observed completing the fire watch per the facility's Allegation of Compliance.	K 062	K 066 Metal containers with self-closing lids were ordered on November 16, 2011 and will be placed when received. Completion Date: November 30, 2011 The Maintenance Director or Maintenance Assistant will conduct checks of smoking areas to ensure metal containers are in place during the monthly preventive maintenance rounds. The checks will be submitted monthly for six months to the Quality Assurance Committee, who will determine the need for future focus. The Director of Maintenance or the Maintenance Assistant will report the findings to the Quality Assurance Committee (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.).	11/30/2011
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 066		

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K 066	Continued From page 6 failed to assure smoking areas were provided with metal containers with self-closing covers. The findings include: Observation and interview with the Maintenance Director, on November 7, 2011 at 3:00 p.m. confirmed two (2) of three (3) smoking areas were not provided with metal trash receptacles that were self-closing .	K 066	K 067 As of November 18, 2011; Bids are being taken from authorized vendors and test will be scheduled and performed per regulation. Completion Date: December 16,2011	12/16/2011
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure fire dampers were maintained in accordance with NFPA 90A. NFPA 90A, 3-4.7 states: Maintenance - At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. The findings include: Observation, record review and interview with the Maintenance Director on November 7, 2011 at 11:00 a.m. confirmed the facility failed to perform the 4-year required maintenance to fire dampers.	K 067	On November 18, 2011 an audit tool was created to track the due date of the fire damper test. The Director of Maintenance or the Maintenance Assistant will report the findings of the audit tool to the Quality Assurance Committee (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.) on a yearly basis.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in	K 144		

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K 144	Continued From page 7 accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide the emergency generator with an operable remote annunciator in a continuously monitored location. (NFPA 99, 3-4.1.1.15 and NFPA 70, Section 700-12) The findings include: Observation and interview with the Maintenance Director, on November 7, 2011 at 3:40 p.m. confirmed the emergency generator remote annunciator was inoperable. The findings include: Observation during the Emergency Generator transfer with the Maintenance Director, on November 7, 2011 at 1:00 p.m. revealed the remote annunciator was inoperable, the light indicating " Generator running " was not illuminated, and the lamp test button was inoperable. Based on observation and interview, the facility failed to assure the emergency generator automatic transfer switch would transfer the load in less than 10-seconds. The findings include: Observation of the Emergency Generator transfer with the Maintenance Director, on November 7, 2011 at 1:00 p.m. revealed the generator load	K 144	K 144 On November 18, 2011 annunciator panel was ordered and will be installed when received. Transfer switch will be checked and corrections made as needed. Completion date December 16, 2011 The Director of Maintenance or the Maintenance Assistant will make checks of the generator system during monthly preventive maintenance rounds. An issues found during rounds will be reported to the Administrator.	12/16/2011

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K 144	Continued From page 8 transferred in 12 seconds.	K 144	K 154	
K 154 SS=L	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the facility's fire watch policy was implemented when the sprinkler system trip test failed to activate in the required 60 seconds and remained inoperable for more than 4 hours. The facility's failure placed all 161 residents in the facility in Immediate Jeopardy (a situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious harm, injury, impairment or death. The Administrator was notified of the Immediate Jeopardy on November 7, 2011 at 4:00 p.m. in the Administrator's office. The findings include: Record review and interview with the Maintenance Director, on November 7, 2011 at 3:45 p.m. revealed the dry system trip test report from October 10, 2011 resulted in an unacceptable trip time of 8 min 30 seconds. This	K 154	On November 7, 2011 the fire watch policy was implemented immediately by the Director of Maintenance. On November 8, 2011 an addendum was made to the fire watch policy, the local fire department was notified and in service training was provided to designated fire watch staff. Beginning on November 7, 2011 the fire watch policy will stay in effect until the new sprinkler system is inspected and the Department allows us to lift the watch. On November 18, 2011 the Assistant City of Kingsport Fire Marshall inspected the new system. Also training was done with the Kingsport Fire Department on the new system. On November 18, 2011 at approximately 1:15 pm per a phone conversation with State Fire Inspector fire watch was lifted for the building. Beginning on November 8, 2011 and ongoing the staff were educated by the Maintenance Director and\or the Director of Environmental Services on the updated Fire Watch policy. In service will be added to the employee orientation packet.	11/21/2011

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K 154	Continued From page 9 failed to meet the 60-second limit for water to flow from the inspectors test valve connection and indicated the sprinkler system failed to function as designed and was inoperable. The facility incorrectly initiated their fire watch policy at 4:55 p.m. on November 7, 2011. Record review of the fire watch policy and interview with the Maintenance Director, on November 7, 2011 at 3:45 p.m. revealed the facility failed to properly follow their firewatch policy. The facility failed to notify the local fire department and State Licensing agency when the sprinkler system was found to be inoperable on October 10, 2011. On November 7, 2011, when the firewatch was originally implemented, the facility failed to inspect the attic area for fire or smoke. The Immediate Jeopardy was removed on November 8, 2011 at 2:40 pm when the facility provided an acceptable Allegation of Compliance with an addendum to their firewatch policy, notified the local fire department, and conducted in-service training for designated firewatch staff, and included the attic spaces in the firewatch areas. The scope and severity for K-154 was lowered from an "L" level to a "F" level. Interviews and observations on November 8, 2011 beginning at 9:10 a.m. with Certified Nursing Assistants, Licensed Practical Nurses, Registered Nurses, Physicial Therapy Aides, Technicians, and the Director of Nursing revealed staff had been in-serviced related to the need for the fire watch and facility staff were observed completing the fire watch per the facility's Allegation of Compliance.	K 154	K 154 cont. Annual in service for the Fire watch policy will be provided to the staff by the Director of Maintenance or the Director of Environmental Services. The results of the annual in service will be reported to the Quality Assurance Committee. The Director of Maintenance or the Maintenance Assistant will report the findings to the Quality Assurance Committee (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.).	